STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
l I		IDENTIFICATION NUMBER:	A. BUILDING	01	COMP		
		155474	B. WING		06/17/2	2011	
NAME OF PROVIDER OR SUPPLIER			1	EET ADDRESS, CITY, STATE, ZIP C	CODE		
BREMEN	I HEALTH CARE C	ENTER	316 WOODIES LANE BREMEN, IN46506				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CO		(X5) COMPLETION	
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
K0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCE)		DATE	
KUUUU							
	A Life Safety	Code Recertification	K0000	The facility requests	•	1	
	_	ensure Survey was		of correction be cons			
		the Indiana State		credible allegation o Preparation and/or e			
	_	f Health in accordance		this plan of correctio	n does not		
	•			constitute admission			
	with 42 CFR 4	+03./U(a).		agreement by the pr truth of the facts alle			
	_	0.614 = 14.4		conclusions set forth	in the		
	Survey Date:	06/17/11		statement of deficier			
	Facility Number: 000506				plan of correction is prepared and/or executed solely because it is required by the provisions of		
				I			
	Provider Num	ber: 155474		federal and state lav	٧.		
	AIM Number: 100266530						
	Surveyor: Richard D. Schade, Life						
	Safety Code S	· · · · · · · · · · · · · · · · · · ·					
	Surety Code B	peciansi					
	At this Life Sa	afety Code survey,					
	Bremen Healt	h Care Center was					
	found not in c	ompliance with					
		for Participation in					
	_	dicaid, 42 CFR					
		0(a), Life Safety from					
	•	• * * * * * * * * * * * * * * * * * * *					
	Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies						
	and 410 IAC	16.2.					
LABORATOR	Y DIRECTOR'S OR PROV	VIDER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE		(X6) DATE	

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: Facility ID: 000506

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/11/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155474		<u> </u>	LDING	NSTRUCTION 01	(X3) DATE COMPI 06/17/2	LETED		
NAME OF PROVIDER OR SUPPLIER BREMEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LANE BREMEN, IN46506					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	construction as sprinklered. To was built in 19 Wing added in East and Loun 1995. The fact system with structure and society of 97 93 at the time Quality Review by Safety Code Special 06/22/11. The facility was compliance with aforementione.	be of Type V (111) and was fully the original building the original building the 300 the 1994 and the 100 ge completed in ility has a fire alarm moke detection in the spaces open to the facility has a and had a census of of this survey. Robert Booher, REHS, Life ist-Medical Surveyor on as found not in th the						

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE S		SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 01 CO		COMPL	COMPLETED		
155474		155474	B. WING 06/17/2			06/17/2	2011	
NAME OF PROVIDER OR SUPPLIER				STREET A	DDRESS, CITY, STATE, ZIP CODE			
					OODIES LANE			
BREMEN	I HEALTH CARE CI	ENTER		BREME	N, IN46506			
(X4) ID		STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		ICY MUST BE PERCEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION DATE	
K0074		s, including cubicle curtains,	+	IAG	Dirichi.e.,		DATE	
SS=E		hanging fabrics and films						
00-L		ings or decorations in health						
		are in accordance with						
		.1 and NFPA 13, Standards of Sprinkler Systems.						
		re in accordance with NFPA						
	701.							
	Nowly introduced	upholstered furniture within						
	•	ancies meets the criteria						
		sted in accordance with the						
		0.3.2 (2) and 10.3.3.						
	19.7.5.1, NFPA 13							
	Newly introduced	mattresses meet the criteria						
		sted in accordance with the						
		0.3.2 (3) , 10.3.4. 19.7.5.3	17.0	074	V 074lt is the prostice of this		07/17/0011	
	Based on obse		K0074	0/4	K-074It is the practice of this facility to ensure the highest		07/17/2011	
	ŕ	facility failed to			quality of care is afforded our			
	•	es, curtains and			residents. Consistent with this practice, the following has been done: The corrective action taken			
		ng as furnishings						
		sistant in 2 of more			for the residents found to ha			
	than 80 rooms	in accordance with			been affected by the deficier practice wasNo residents aff			
	LSC 10.3.1. T	This deficient practice			by the deficient practice. The corrective action taken for those residents having the potential to be affected by the same deficient practice is No residents affected by the deficient practice. The measures put into place and a systemic change made to ensure			
	affects any res	sidents, staff and						
	visitors in and	near the class room						
	and lounge.							
	Findings inclu	de·						
		iuo.			the deficient practice does no			
	B 1 1 2 24 4				recur isThe nine sets of curta			
		ervation with the			in the lounge and the window treatments in the classroom have			
	_	istrator on 06/17/11			been treated with an approve			
	between 2:15	p.m. and 3:10 p.m.,			NFPA fire retardant spray. To			
					facility will perform an audit o	on		

000506

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155474		A. BUIL	DING	NSTRUCTION 01	(X3) DATE S COMPL 06/17/2 (ETED		
NAME OF PROVIDER OR SUPPLIER BREMEN HEALTH CARE CENTER			B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LANE BREMEN, IN46506					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E.	(X5) COMPLETION DATE	
	documentation being treated was for three wind class room and in the lounge. acknowledged observations, he evidence of firmaterials being retardant. 3.1-19(b)	ne did not have re resistance of g treated with a fire			one third of the building every month and materials will be treated with fire retardant spin necessary. All documentation new and old materials will be in a binder. To ensure the def practice does not recur, the monitoring system established Performance Improvement indicator has been established which evaluates compliance documentation regarding flar retardant materials. The Executive Director or designed will complete the indicator monthly for the first quarter a quarterly thereafter with resurforwarded to the facility performance improvement committee for further evaluate or resolution.POC Date: 07/17/2011:: ::	ray if n of kept icient ed isA with ne ee		
K0143 SS=B	wherein patients a treated by a separ 1-hour fire-resistive (b) in an area that sprinklered, and har flooring; and (c) in an area post transferring is occur the immediate areaccordance with N Compressed Gas Based on obse	parated from any portion of a facility patients are housed, examined, or by a separation of a fire barrier of ire-resistive construction; area that is mechanically ventilated, red, and has ceramic or concrete			07/17/2011			

000506

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· ·	(X2) MULTIPLE CONSTR			(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155474	A. BUILD	ING	01	06/17/20		
1.55		B. WING	CTDEET A	DDRESS, CITY, STATE, ZIP CODE	00/17/20			
NAME OF PROVIDER OR SUPPLIER					ODIES LANE			
BREMEN HEALTH CARE CENTER				BREMEN, IN46506				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	l n	ID REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		1	TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE	
		iquid oxygen storage			is afforded our residents.			
		ovided with signage			Consistent with this practice, the following has been done:			
	_	gen transferring is			The corrective action taken f	or	r	
	l	is deficient practice			the residents found to have la affected by the deficient prac-			
	could affect re	sidents, staff and			was			
	visitors in and	near the oxygen			No residents affected by the deficient practice.			
	storage and tra	nsfilling room.			The corrective action taken t	or		
					those residents having the	_		
	Findings inclu	de:			potential to be affected by th same deficient practice is	e		
					No residents affected by the			
	I Baced on oncert/allon Williame		deficient practice. The measures put into place	I				
	facility admini			a systemic change made to				
	tour of the facility at 3:35 p.m. on 06/17/11, the facility's oxygen storage and transfilling room was			ensure the deficient not recur is		does		
					The facility has posted a sign by the oxygen storage room that			
	not provided v	not provided with a sign indicating transferring of oxygen was occurring. Based on interview at			indicates transfilling of oxyge To ensure the deficient pract			
	transferring of				does not recur, the monitoring	ng		
	occurring. Ba				system established is This is the only oxygen room	that		
	the time of observation, the				the facility has to store oxyge	en.		
	administrator a	administrator acknowledged the			The transfilling sign has been posted so no further action of			
	transferring of	oxygen does occur			monitoring for this deficient			
	' ' '	in the oxygen storage and			practice. POC Date: 07/17/2011			
	_	ing room and no sign	:: ::					
	_	transferring of						
	• •	xygen was occurring in the						
	facility's oxygen storage and							
	transfilling roo	oms was provided.						
	3.1-19(b)							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155474	(X2) MULTIPLE CO A. BUILDING B. WING	01		E SURVEY PLETED '2011		
NAME OF PROVIDER OR SUPPLIER BREMEN HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 316 WOODIES LANE BREMEN, IN46506					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	RRECTION HOULD BE APPROPRIATE	(X5) COMPLETION DATE		